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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200024	A. BUILDING _____ B. WING _____	R-C 04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MAINE MEDICAL CENTER	300 MAIN STREET LEWISTON, ME 04240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS 1st Revisit to Federal Complaint: #29471 Revisit Survey Dates: 4/11/19, 4/12/19, and 4/16/19 Three Conditions of Participation identified not in compliance: - §482.12 Condition of Participation: Governing Body also known as A-0043. - §482.21 Condition of Participation: Quality Assessment and Performance Improvement also known as A-0263. - §482.55 Condition of Participation: Emergency Services also known as A-1100. Repeat Deficiencies Identified: - §482.12 Condition of Participation: Governing Body also known as A-0043. - §482.21 Condition of Participation: Quality Assessment and Performance Improvement also known as A-0263. - §482.55 Condition of Participation: Emergency Services also known as A-1100. On 4/11/19, 4/12/19, and 4/16/19, revisits surveys were conducted at Central Maine Medical Center, an Acute Care Hospital. These revisit surveys identified that the hospital was not in substantial compliance with the 42 Code of Federal Regulations Part 482, the Conditions of Participation: Governing Body (§482.12), Quality Assessment and Performance Improvement	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief President — (X6) DATE: 5/3/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Central Maine Medical Center

Statement of Deficiencies date April 16, 2019

Plan of Correction

A000

CARE FACILITATION

A competency validation and performance monitoring / improvement method we call "Care Facilitation" is mentioned throughout this plan of correction. Care Facilitation has the following features:

Care Facilitators are individuals who have been trained in the Care Facilitation process and in the hospital's expectations for the process under review (which is typically a clinical process).

The Care Facilitator engages with a front-line caregiver (physician, nurse, technician, etc.) as care or service is in progress (concurrently).

The care or service provided and corresponding documentation is concurrently reviewed for compliance with hospital policy / protocol.

Deviations from expected practice are corrected in real time, including completion of missing documentation (if indicated) through an identified "late note."

The Care Facilitation process is intended to identify and correct errors before they reach the patient. It also provides real-time feedback and support for front-line personnel.

Information is collected for each Care Facilitation interaction. The data set gathered typically focuses on five to seven expectations, such as staff member knowledge of hospital policy, staff member understanding of clinical issues (e.g. the accuracy of triage scores), successful completion of expected processes, and the completeness and accuracy of documentation. For every "No" answer in the facilitation data set, the Care Facilitator indicates whether the deficient practice was corrected.

Possible responses to individual Care Facilitation questions are:

"**Yes**" (the correct process, understanding or documentation was in place),

"**No**" (the correct process, understanding or documentation was not in place), and

"**No-Corrected**" (the deficient process, knowledge or documentation was successfully corrected during the Care Facilitation interaction).

Data collected during Care Facilitation interactions are aggregated and reviewed by leadership on an ongoing basis. For example, the responsible manager for the unit or service will review the data each business day, and the Executive Oversight Team (described elsewhere in this plan of correction) will review the data during its weekly) meetings.

The Care Facilitation process yields rapid improvement while protecting patients as care processes are improved.

Data suggesting the need for prolonged Care Facilitation can be a signal of defective process design in the action plans. Care Facilitation either brings about prompt improvement or it focuses our attention on flaws in process design. (e.g., Is the staffing level adequate? Is the expectation realistic? Are qualifications appropriate?). In short, if improvement is not rapid there is probably something wrong with our expectation.

Issues to be addressed through Care Facilitation include:

- Implementation of an evidence-based cardiac chest pain protocol;
- Implementation of evidence-based spine precautions;
- Triage, including the accurate implementation of the Emergency Severity Index;
- Bed placement within the emergency department; and
- Monitoring of patients awaiting a medical screening examination.

OVERALL RESPONSIBILITY FOR THE CARE FACILITATION PROCESS:

Chief Quality Officer

DATE CARE FACILITATION WILL BEGIN

May 10, 2019

A 043

A 083

42 CFR 482.12 (e)

CONTRACT MONITORING / TEMPORARY NURSING SERVICE

CORRECTING THE DEFICIENCY

The hospital immediately discontinued the use of the temporary nursing service referenced in the statement of deficiencies. The hospital re-commenced the use of the service once documentation of approval by the State of Maine was provided.

IMPROVING THE UNDERLYING PROCESS

The due diligence checklist used to review contracts by the office of general counsel has been updated to ensure that: (a) the required registration for temporary nurse staffing agencies is checked against the State of Maine registration website; and (b) the actual registration certificate is obtained from each nurse staffing agency.

PROCEDURE FOR IMPLEMENTATION / MONITORING

The expiration dates for required certificates, such as State registrations are entered into the electronic contract management system, which prompts the responsible contract specialist at sequential 90/60/30 days to expiration intervals to secure an updated registration certificate from the applicable nurse staffing agency.

RESPONSIBLE PARTY

General Counsel

COMPLETION DATE

April 22, 2019

A 043

A 092

42 CFR 482.12 (f)(1)

GOVERNING BODY RESPONSIBILITY: LACK OF COMPLIANCE WITH THE EMERGENCY SERVICES CONDITION OF PARTICIPATION

CORRECTING THE DEFICIENCY

A consulting company with a national practice in compliance with the Medicare Conditions of Participation (The Greeley Company) has been engaged to partner with hospital leaders, clinicians and staff members to correct deficient practices and report to executive leadership on progress. A leadership team, including the Chief Quality Officer and the Chief Operating Officer, will work with Greeley to identify and remediate deficient practices within the Governing Body, Quality Assessment and Performance Improvement, and Emergency Services Conditions of Participation. Progress reports will be overseen by the Executive Oversight Team, which meets on a weekly basis. The Executive Oversight Team includes the Hospital President, the Chief Quality Officer, the Chief Nursing Officer, the Chief Operating Officer and the Health System's General Counsel. The Executive Oversight Team or its successor will provide routine reports to the Board Quality Committee at least quarterly or more often should a compliance or significant safety concern arise.

IMPROVING THE UNDERLYING PROCESS

As the Executive Oversight Team works with physician and nursing leaders of the emergency department, it will evaluate and, when indicated, improve the process for ongoing oversight of quality, safety and efficiency. The goal will be to improve prompt and effective communication of safety and compliance vulnerabilities between departmental leaders and the executive / governance team.

PROCEDURE FOR IMPLEMENTATION

The Executive Oversight Team ("EOT") will adopt a charter that specifies its accountability for oversight of compliance with the Conditions of Participation. Its meetings, which will be held weekly until known deficient practices are corrected, will be facilitated by the

hospital's Results Management Office (RMO) and Quality departments. Once the hospital's current compliance challenges are resolved, the EOT will make recommendations for ongoing oversight of compliance at the executive level.

RESPONSIBLE PARTY

President, Central Maine Medical Center

COMPLETION DATE

May 2, 2019

A 043

42 CFR 482.12

GOVERNING BODY RESPONSIBILITY: COMPLIANCE WITH APPROVED PLAN OF CORRECTION

CORRECTING THE DEFICIENCY

All training promised in the previous plans of correction was completed on May 2, 2019. Employees and contract personnel who were off duty during the training period will receive relevant information in an update within two weeks of their return to service. Relevant topics have also been included in the new employee orientation process.

IMPROVING THE UNDERLYING PROCESS

The Executive Oversight Team will oversee a work plan designed to track all commitments made in this plan of correction. Plans of correction for any future deficiency statement will be similarly tracked and overseen by the EOT or its successor.

PROCEDURE FOR IMPLEMENTATION

Each component of the accepted plan of correction will be entered into an on-line tracking tool. As each element of the plan is completed, it will be validated by a representative of the Quality department. Evidence of completion will be attached to the tracking tool and available for review upon request.

MONITORING

The Executive Oversight Team will receive reports on completion of the various elements of this plan of correction during its weekly meetings.

RESPONSIBLE PARTY

President, Central Maine Medical Center

COMPLETION DATE

May 10, 2019

A 263

42 CFR 482.21

QAPI PROGRAM: COMPLIANCE WITH APPROVED PLAN OF CORRECTION

CORRECTING THE DEFICIENCY

All training modules and other actions promised in the previous plans of correction were completed on May 2, 2019. Employees and contract personnel who remained off duty as of that date will receive relevant information in an update when they return to service. Relevant topics have also been included in the new employee orientation process.

IMPROVING THE UNDERLYING PROCESS

The Executive Oversight Team will oversee a work plan designed to track all commitments made in this plan of correction. Plans of correction for any future deficiency statement will be similarly tracked and overseen.

Ultimately, the Executive Oversight Team will develop a sustainable, long-term process of executive oversight of significant compliance vulnerabilities. For example, EOT oversight functions may be handed off to another executive-level group as a permanent accountability.

PROCEDURE FOR IMPLEMENTATION

Each component of the accepted plan of correction will be entered into an on-line tracking tool. As each element of the plan is completed, it will be validated by a representative of the quality department. Evidence of completion will be attached to the tracking tool and available for review upon request.

MONITORING

The Executive Oversight Team will receive reports on the completion of the various elements of this plan of correction during its weekly meetings.

RESPONSIBLE PARTY

President, Central Maine Medical Center

COMPLETION DATE

May 10, 2019

A 1100

42 CFR 482.55

TIMELINESS OF PATIENT CARE / PATIENT MONITORING / TREATMENT OF CHEST PAIN

CORRECTING THE DEFICIENCY / IMPROVING THE UNDERLYING PROCESS

There are three components to the correction of this issue: 1. The accuracy of triage, 2. the care of patients with chest pain of possible cardiac origin, and 3. the prompt evaluation of other high risk patients.

The hospital will clarify and optimize its processes for the care of patients requiring prompt attention. For example:

- Patients assigned Category 2 (Emergent) on the 5-point Emergency Severity Index (ESI-2) will be seen by a provider as soon as possible to evaluate whether immediate medical or surgical intervention is indicated.ESI-2 patients will be brought directly into the main emergency department rather than returning to the waiting room pending a provider evaluation. In the event that a provider has not seen the patient within approximately 30 minutes, the ESI-2 patient will be reassessed by a registered nurse(vital signs included).Based upon the RN re-assessment, a "provider urgent" page may be broadcast, which prompts on-duty emergency medicine providers to respond at once to evaluate the patient.
- Patients apparently suffering from cardiac chest pain will likewise be promptly evaluated by a practitioner to determine whether immediate treatment and enhanced monitoring is indicated.
- Patients categorized as ESI-3 should be seen by a provider within approximately 2 hours of arrival. Should such a patient wait longer than approximately 2 hours for a provider examination, (s)he will be reassessed by a registered nurse, including a re-evaluation of vital signs.
- An additional triage nurse will be assigned from 10AM until 10PM every day to assist in patient monitoring, patient bed placement, staff assignment, the prompt evaluation of ESI-2 and cardiac chest pain patients, and triage.
- Surge triggers will be developed that will prompt the charge nurse (if free) or providers (physicians and associate professional staff) to deploy to the waiting room to assist in patient triage, monitoring and bed placement. Examples of possible triggers include:

four or more patients waiting to be triaged; one or more ESI-2 patients awaiting a provider evaluation in the waiting room.

PROCEDURE FOR IMPLEMENTATION

Precise expectations such as the exact trigger-and-response mechanisms related to the above changes are currently under development. The Care Facilitation model described at A000 of this Plan of Correction will provide objective data and feedback as the organization fine tunes its policies, procedures, protocols and training.

Once applicable policies, procedures, protocols and training materials are finalized, each staff member will receive individual education on any process changes and have their practice reinforced through Care Facilitation.

MONITORING

Care Facilitators will have contact with all shifts to review the following processes:

- triage,
- bed placement,
- provider evaluation of ESI 2 patients,
- provider evaluation of cardiac chest pain patients, and
- provider evaluation and reassessment of ESI 3 patients.

Care Facilitation will provide a redundant layer of patient protection as the organization tests and refines its surge, bed placement and provider evaluation practices.

RESPONSIBLE PARTY

Chief Operating Officer

COMPLETION DATE

June 3, 2019

A 1100

42 CFR 482.55

SPINE PRECAUTIONS

CORRECTING THE DEFICIENCY / IMPROVING THE UNDERLYING PROCESS

This deficiency reflects variation in the understanding of spinal precautions, since multiple staff members did not seem to recognize that elevating the head of a spinal injury patient's bed is usually contraindicated. We also believe, however, that the clarification of the orders (creating an order set vs. a single order that was modified by the provider) might avoid unnecessary confusion.

Although the policy and order set will be improved and clarified, the underlying lack of a working knowledge of spine precautions will be addressed through individual reinforcement and feedback.

PROCEDURE FOR IMPLEMENTATION

- Training material will be reviewed and focused.
- Nursing personnel in the emergency department will be evaluated to determine their individual knowledge of spinal precautions, especially the general contraindication for raising the head of a spinal-injury patient's bed.
- Orders for spine precautions will be broken down into clear order sets.
- The Care Facilitation process will focus on the successful implementation of spine precautions.

MONITORING

Care Facilitation data will be reviewed by the Department Manager and members of the Executive Leadership Team frequently to monitor the effectiveness of our improvement efforts.

RESPONSIBLE PARTY

Chief Operating Officer

COMPLETION DATE

June 3, 2019

Central Maine Healthcare
The Central Maine Medical Family

FAX

COVER SHEET

To: Marcia Smith
Fax #: 207-287-9252
Subject: CMMC complaint #29471
Date: 05/03/2019
Pages: 12 , including this page

From the desk of...

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